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SPECIFIC ELEMENTS

In addition to the common elements, all surgical services include the following specific elements.

A. Supervising the preparation of and/or preparing the patient for the procedure(s).

B. Performing the procedure(s), by any method, or assisting another physician in the performance of the procedure and carrying out appropriate recovery room procedures, being responsible for the transfer of the patient to the recovery room, ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any related assessments or procedures, including obtaining any specimens from the patient and interpreting the results where appropriate.

D. Where indicated, making or supervising the making of arrangements for follow-up care, and post-procedure monitoring of the patient's condition, including intervening, until the first post-operative visit.

E. Discussion with, providing any advice and information, including prescribing therapy, to the patient or patient's representative(s), whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies and personnel for the specific elements:

a. for services not identified with prefix #, for all elements;

or

b. for services identified with prefix #, for any aspect(s) of A, C, D and E that is(are) performed in a place other than the place in which the surgical procedure(s) is performed.

SURGICAL SERVICES WHICH ARE NOT LISTED AS A "Z" CODE

In addition to the above, the fee for this service includes the following:

1. Pre-operative Care and Visits

Pre-operative hospital visits which take place 1 or 2 days prior to surgery.

2. Post-operative Care and Visits

Post-operative care and visits associated with the procedure for up to two weeks post-operatively, and making arrangements for discharge, to a hospital in-patient except for:

a. the first and second post-operative visits in hospital (payable at the specialty specific subsequent visit fee);

and

b. subsequent visit by the Most Responsible Physician (MRP) - day of discharge (C124).

The specific elements for pre- and post-operative visits are those for assessments.

[Commentary:
For surgical services not listed with a "Z" code, C122 or C123 (subsequent visit by the MRP - day following, or second day following the hospital admission assessment) and C142 or C143 (first and second subsequent visits by the MRP following transfer from an Intensive Care Area/Neonatal Intensive Care) are not eligible for payment to the surgeon for visits rendered either 1 or 2 days prior to surgery or in the first two weeks following surgery.]

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OTHER TERMS AND DEFINITIONS

FOR DEFINITION OF THE ROLE OF THE SURGICAL ASSISTANT - SEE GENERAL PREAMBLE GP54.

FOR DEFINITION OF THE ROLES OF THE ANAESTHESIOLOGIST - SEE GENERAL PREAMBLE GP58.

With the exception of the listings in the "Consultations and Visits" section, all references to surgeon in this schedule are references to any physician performing the surgical procedure.

1. If the surgeon is required to perform a service(s) not usually associated with the original surgical procedure, he/she may claim for these on a fee-for-service basis.

If special visits to hospital are required at any time post-operatively, the surgeon may claim the minimum special visit premiums even if the basic hospital visit fees may not be claimed (under these circumstances the hospital visits should be claimed on an N/C ($00.00) basis).

The surgical benefit as noted above does not include the major pre-operative visit - i.e. the consultation or assessment fee which may be claimed when the decision to operate is made and the operation is scheduled, regardless of the time interval between the major pre-operative visit and surgery.

The hospital or day care admission assessment (consultation, repeat consultation, general or specific assessment or re-assessment, partial assessment) may not be claimed by the surgeon unless it happens to be the major pre-operative visit as defined above.

Routine subsequent hospital visits may be claimed for visits rendered more than two days prior to surgery. Other visits (excluding admission assessments) prior to admission may be claimed for in addition to the surgical fee.

Because the number of hospital visits is limited to three per week after the fifth week of hospitalization and six per month after the thirteenth week of hospitalization, the starting point for calculating the number of hospital visits is based on the date of admission if the operating surgeon has admitted the patient or the date of referral if the patient has been referred to the operating surgeon while in hospital.

The listed benefit for a procedure normally includes repair of any iatrogenic complications occurring during the course of the surgery performed by the same surgeon. Other major interventions should be handled on an individual basis. The surgical benefit includes the generally accepted surgical components of the procedure.

2. When a physician makes a special visit to perform a non-elective surgical procedure, he/she may claim the following benefits for procedures commencing:

a. 07:00h -17:00h - Monday to Friday
A consultation (if the case is referred) or the appropriate assessment, the appropriate special visit premium plus the procedural benefit.

b. 17:00h - 07:00h - Any night or on Saturdays/Sundays or Holidays
A consultation or assessment, the appropriate special visit premium, the procedural benefit plus the surgical premium E409 or E410.

(see General Preamble GP47 to GP52 and GP64).

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3. When more than one procedure is carried out by a surgeon under the same anaesthesia or within 14 days during the same hospitalization for the same condition, the full benefit applies to the major procedure and 85% of the listed benefit(s) applies to the other procedure(s) performed unless otherwise stated in the Preamble(s) or Schedule. The above statement applies to staged or bilateral procedures but does not apply when a normal appendix or simple ovarian or para-ovarian cyst is removed incidentally during an operation, for which no claim should be made.

4. When a subsequent operation becomes necessary for the same condition because of a complication or for a new condition, the full benefit should apply for each procedure.

5. When a subsequent non-elective procedure is done for a new condition by the same surgeon, the full benefit will apply to each procedure. When a subsequent elective procedure is done for a different condition within 14 days during the same hospitalization by the same surgeon, the benefit for the lesser procedure shall be reduced by 15%.

6. When different operative procedures are done by two different surgeons under the same anaesthesia for different conditions, the benefit will be 100% of the listed benefit for each condition. Under these circumstances, the basic assistant's benefit should not be claimed by either operating surgeon; however time units may be claimed.

7. As a general rule, when elective bilateral procedures are performed by two surgeons at the same time, one surgeon should claim for the surgical procedures and the other surgeon should claim the assistant's benefit.

8. Where two surgeons are working together in surgery in which neither a team fee nor other method of billing is set out in the benefit schedule, the surgeon should identify him/herself as the operating surgeon and claim accordingly; the surgeon who is assisting the operating surgeon should identify him/herself as such and claim the assistant's benefit.

Where the second or assistant surgeon is brought into the case on a consultation basis, he/she may, when indicated, claim a consultation as well but should be prepared to justify it on an IC basis.

If the nature or complexity of a procedure requires more than one operating surgeon, each providing a separate service in his/her own specialized field, e.g. one surgeon carries out the ablative part and another surgeon the reconstructive part of the procedure, then each surgeon should claim the listed benefit for his/her services. This statement applies when the additional procedure(s) are not the usual components of the main procedure. If one surgeon, in addition to performing a specialized portion of a procedure, acts as an assistant during the remainder of the procedure, he/she may also claim time units for assisting.

When surgical procedures are rendered to trauma patients who have an Injury Severity Score (ISS) of greater than 15 for individuals age 16 or more, or an Injury Severity Score (ISS) of greater than 12 for individuals less than age 16, and it is required that two surgeons perform components of the same procedure, the full surgical fee for that procedure is payable to each surgeon.

9. Unless otherwise stated, the listed benefits are for unilateral procedures only.

10. When a procedure is performed, a procedural benefit, if listed, should be claimed. Substitution of consultation and/or visit benefits for procedural benefits (except as in paragraph 9), is not in keeping with the intent of the benefit schedule.

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11. When a surgical benefit (non-IOP, Complete Care, Fracture or Dislocation) is less than the surgical consultation benefit, and the case is referred, a physician may claim a surgical consultation benefit instead of the surgical benefit. However, to avoid the consultation being counted as such under the Ministry of Health and Long-Term Care limitation rules on the number of consultations allowed per year, the physician should claim the consultation fee under the surgical procedure nomenclature or code. Since the consultation is replacing a procedural benefit which includes the pre- and post-operative and surgical care, no additional claims beyond the consultation should be made.

12. If a physician performs a minor surgical procedure and during the same visit assesses and treats the patient for another completely unrelated and significant problem involving another body system, the physician should claim for the procedure as well as the appropriate assessment.

13. Where a procedure is listed with a "Z" code, the procedure is an "Independent Operative Procedure (IOP)" and the procedural benefit should be claimed in full along with the appropriate consultation or assessment when both services are actually rendered. However, when an IOP is done in conjunction with a non-IOP, there should be no claim for the consultation or pre- and post-operative care related to the IOP. The listed IOP benefit should be claimed in these circumstances along with the non-IOP benefits plus the related major pre-operative visit.

When multiple or bilateral IOP are performed at the same time by the same physician, the listed procedural benefits should be claimed in full but the pre- and post-operative benefits should be claimed as if only one procedure had been performed.

When a patient is examined in a physician's office and this leads to an elective Independent Operative Procedure (IOP) being performed for the same problem or diagnosis by the same physician in the Emergency or Out-patient Department on a non-admission basis, the physician should claim a consultation or visit for the examination in the office and the fee for the IOP carried out in the Emergency or Out-patient Department. An additional assessment benefit at the time of the elective IOP should only be claimed when an additional assessment is performed.

14. When procedures are specifically listed under Surgical Procedures, surgeons should use these listings rather than applying one of the plastic surgery listed fees under Operations on Skin and Subcutaneous Tissue.

15. For excision of tumours not specifically listed in this Schedule, claims should be made on an IC basis (code R993). Independent Consideration also will be given (under code R990) to claims for other unusual but generally accepted surgical procedures which are not listed specifically in the Schedule (excluding non-major variations of listed procedures). In submitting claims, physicians should relate the service rendered to comparable listed procedures in terms of scope and difficulty (see General Preamble GP12).

16. **Cosmetic or Esthetic Surgery:** means a service to enhance appearance without being medically necessary. These services are not insured benefits (see Appendix D.)

17. Reconstructive Surgery: is surgery to improve appearance and/or function to any area altered by disease, trauma or congenital deformity. Although surgery solely to restore appearance may be included in this definition under certain limited conditions, emotional, psychological or psychiatric grounds normally are not considered sufficient additional reason for coverage of such surgery. Appendix D of this Schedule describes the conditions under which surgery for alteration of appearance only may be a benefit. Physicians should submit requests to their regional OHIP Office for authorization of any proposed surgery which may fall outside of Ministry of Health and Long-Term Care coverage. (See Appendix D.)

18. Additional claims for biopsies performed when a surgeon is operating in the abdominal or thoracic cavity will be given Independent Consideration.

19. When a listed procedure is performed and no anaesthetic is required, the procedure should be claimed under the “local anaesthetic” listing.

20. When a physician administers an anaesthetic, nerve block and/or other medication prior to, during a procedure(s) or immediately after a procedure(s), which the physician performs on the same patient, the administration of the anaesthetic, nerve block or other medication is an insured service payable at nil. However, when a physician administers an ankle, pudendal, brachial plexus, femoral, intercostal, sciatic, ilioinguinal, iliohypogastric, ulnar, median or radial block in addition to performing a procedure, the block is payable as G224 (see Nerve Blocks in Diagnostic and Therapeutic Procedures Section) in addition to the procedure. With the exception of a bilateral pudendal block, this fee is payable once per region per side where bilateral procedures are performed.

21. If claims are being submitted in coded form, the surgeon should add the suffix A to the listed procedural code, the surgical assistant should add the suffix B to the listed procedural code and the anaesthetist should add the suffix C to the listed procedural code.

22. When Z222/Z223 is claimed for a patient for whom the physician submits a claim for rendering another insured service on the same day, the amount payable for Z222/Z223 is reduced to nil.

23. When a surgical procedure is attempted laparoscopically in the digestive system or the female genital system, but requires conversion to a laparotomy, unless otherwise specified, the diagnostic laparoscopic fee E860 is payable in addition to the procedural fee.

24. Morbidly Obese Patients

E676 is payable as listed, once per patient per physician in addition to the amount payable for the major surgical procedure(s) where a morbidly obese patient undergoes major surgery to the neck or trunk and:

a. the patient has a Body Mass Index (BMI) greater than 45: where BMI is defined as the ratio of the patient’s mass (in kilograms) to the square of the patient’s height (in metres) and the BMI is recorded in the patient’s medical record;

b. the surgery is performed using an open technique which is either performed through an incision into a body cavity or is major neck surgery and is performed under general anaesthesia;

and

c. the principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, laparoscopy, cautery, ablation nor catheterization.

E676A	Morbidly obese patient, surgeon . . . . . add	62.55
E676B	Morbidly obese patient, surgical assistant . . . . . add	62.55

[Commentary:
E676 is not eligible for payment if the BMI is not recorded in the patient's medical record or if the surgery is performed under local or regional anaesthesia.]

25. Lysis of extensive intra-abdominal adhesions and/or scarring e.g. post radiation

E673 is payable to the surgeon in addition to the fee for the major intra-abdominal procedure only when lysis requires at least 60 minutes beyond the average duration of the major procedure. E673 less than 60 minutes in duration or rendered in conjunction with E718 is an insured service payable at nil.

# E673	Lysis of extensive intra-abdominal adhesions	add	62.05

26. Intraoperative monitoring of cranial nerves

# E806	- intraoperative monitoring of cranial nerves remote from the skull base, to E314, E315, E316, E320, E322, E325, E326, E327, E332, E338, E339, E341, E345, E903, E957, E981, R910, R911, R915, S002, S042, S043, S044, S045, S046, S047, S058, S788, S789, S790.	add	125.00

27. Cancelled surgery – surgical services

a. If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.

b. When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the surgeon has scrubbed but is not required to do anything further, the service constitutes E006A and the amount payable is calculated by adding the time units to 6 basic units and multiplying by the surgical assistant's unit fee.

c. If the operation is cancelled after surgery has commenced but prior to its completion, the service is eligible for payment under independent consideration (R990).

[Commentary:
Submit claim for R990 by adding the time units to the listed procedural basic units and multiplying by the surgical assistant's unit fee and attach a copy of the operative report for review by a medical consultant.]

Note:
For the purpose of cancelled surgery, time units for the surgeon are calculated in the same way as time units for the surgical assistant (see General Preamble GP54).